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MAY 23 1950

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184

Contents:

The Survival Function of Schizophrenia. *By* John N. Rosen, M.D. 81

Interim Report of the Research Project on the Selection of Medical Men for Psychiatric Training. *By* Lester B. Luborsky, Ph.D., Robert R. Holt, Ph.D. and William R. Morrow, Ph.D. 92

The Kansas Boys' Industrial School Treatment Program. *By* Ralph W. Coltharp, M.D. and George H. Weber, M.A. 102

Coronary Occlusion in Relation to Ambitious Strivings. *By* Howard Williams, M.D. 108

Book Notices 111

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THE SURVIVAL FUNCTION OF SCHIZOPHRENIA

By JOHN N. ROSEN, M.D.*

Freud stated many times in his writings that psychoanalysis is not only a therapy but a method of investigation. In his earlier experience he believed that the psychoanalytic method was not applicable to the psychoses and he stated as a preface to the Schreber case that, "The analytic investigation of paranoia presents difficulties of a peculiar nature to physicians who, like myself, are not attached to public institutions. We cannot accept patients suffering from this complaint, or at all events, we cannot keep them for long, since we cannot offer treatment unless there is some prospect of therapeutic success." Most of Freud's energy and skill, therefore, was applied to the treatment and understanding of the neuroses.

Undoubtedly much of the confusion that arises in the discussions about whether psychoanalysis is applicable to the psychoses is due to the fact that the term schizophrenia has become a "catch-all" classification which is used to describe everything from a borderline case with predominantly neurotic symptoms to a florid acute psychosis. The type of patient that I am talking about when I use the term "deteriorated schizophrenic" is one who would scarcely understand what I meant were I to ask him to follow the fundamental analytic rule of free association, to say nothing of his inability to focus his attention so that he could carry out this most intricate task.

In discussing the dream, Freud says, "Nevertheless, it (the dream) is a psychosis, and we learn from it that even so deep-going a modification of mental life as this can be undone and can give place to normal functioning. Is it too bold, then, to hope that it must also be possible to submit the *dreaded spontaneous illnesses* of the mind to our control and bring about their cure?"

Freud said that the dream is "the royal road to the unconscious." I think it is even more true to say that schizophrenia is the royal road to the unconscious. In the dream, one has the unconscious under scrutiny for a brief moment. In schizophrenia, the dream goes on and on and offers an

* New York, N. Y.

unparalleled opportunity for study of the pathological process without concern that the microscopic slide will suddenly be snatched from view. The unconscious material appears without interference from healthy resistances, exposing a variety of core conflicts which are only shabbily disguised.

To simplify what I have to say, I shall use a patient's term, *imaginations*, which will at once include delusions, hallucinations and all the other instances of psychotic irrationality. Why do these *imaginations* take on the force of reality? Why is this system so unshakeable through ordinary means of assault? No amount of logic, no pleading, no appeal to consider the welfare of others, not even the threat of burning at the stake, can shake such a construction. The delusion, like its anatomical counterpart, scar tissue, is much tougher and more impervious to destruction than the healthier parenchyma which it replaces. Surely there is serious purpose behind the schizophrenic construction. The unconscious may be accused of lack of judgment, but it cannot be accused of lack of function. It would not be surprising if at some future date it is shown that the purpose and the direction of evolution is in some way the responsibility of the forces contained in the unconscious.

The schizophrenic process cannot be lightly dismissed because its implications are not immediately clear. What the total function of schizophrenia is, I don't know. Certain aspects of it I think I do know and something of this I shall try to convey to you.

One patient who thinks his mother died two thousand years ago is certain that this is so. Another, who thinks he is Moses is equally certain. In a normal person, this false reality obtains in dreams, and here the dynamics are essentially the same as in schizophrenia. (It should be noted that imaginations with the force of reality may also be induced by drugs, toxins and organic pathological changes.)

The wish that something should be so is not sufficient in itself to produce the certainty described. Some wishes hardly make any impact on consciousness, others produce mild phenomena like daydreams. When a wish for something is so important that it involves a matter of life and death, then and then only does the unconscious part of the psychic apparatus spring into action and provide the necessary gratification with an *imagination*.

Some time ago I heard the story of a soldier lost in the African desert who almost died of thirst. He was found unconscious, with his mouth and throat full of sand. When he recovered he reported that he had suffered thirst for a number of days. Finally, wherever he looked he saw water and remembered falling down and scooping up handfuls of it, which was wet and cool to his touch and refreshing to taste. It seemed so real at the time that he found it hard to believe later that he had been drinking sand and not water. This recalled similar stories about starving, shipwrecked men

who had fancied themselves enjoying sumptuous banquets and about Alpine climbers, lost in blizzards, who had imagined themselves sitting around warm fireplaces in comfortable inns.

In these cases the wish for water, food or warmth was so urgent and the consequences of non-fulfillment so catastrophic that, at the point of physical collapse, the unconscious was able to provide imaginary food and water and warmth.

Since it is intended to refer to such experiences again in this paper and in future writings, I should like to call it the *mirage principle*. I am aware, of course, that technically such an experience is not a mirage.

In these examples, I think we can find a condition common to all imaginative experiences which gain the force of reality: *A matter of life and death is involved*. If an *imagination* is experienced by a non-psychotic person as a psychological response to a life-threatening deprivation (mirage principle), it seems logical to assume that the *imagination* of the psychotic is a psychological response to something that *he conceives to be* a death-threatening deprivation.

Study of one of my patients who said, "I am Jesus Christ," revealed that his pre-psychotic life was involved with a story that he called, "Hamlet Castle." Every thought in it concerned his enormous temptation to seduce his mother. While being consumed by the relentlessness of this intense wish, he was carrying on an unsatisfactory homosexual affair with his brother. His realistic behavior showed a constant preoccupation with incest and homosexuality. For him, it was the frying pan or the fire. Both threatened him with castration, i.e., biological death. One can easily imagine how this conflict drained his psychological energies and how much he wished to be normal and pure like other people. At the point of psychological exhaustion and with biological death imminent he no longer merely wished he were pure, he became the purest of the pure. He identified himself with Christ, let his hair and beard grow and became increasingly ascetic both in habit and appearance. He was safe at last.

Another patient, a woman in her early forties referred to herself as "The Holy Trinity." Although this patient was raised in a very religious community where all forms of sexuality were strictly forbidden to the "good girls," she exhibited herself to her brother and indulged in a good deal of homosexual play with a sister and a niece. When she married, she was able to tolerate sexual relations with her husband only if she could imagine that he was a negro. She gave birth to a daughter and was horrified to discover that she enjoyed handling the child's genitals. Her homosexual interest in her daughter provoked increasing anxiety, and for many years she lived in fear that she would die of heart trouble or of "some terrible disease." Doctors could find nothing wrong with her except an ulcer, which

cleared up when she was put on a diet. She complained so much about her symptoms that her family finally took her to the Mayo Clinic where her complaints were diagnosed as psychosomatic in origin. Several months later she became psychotic. I suspect that if this patient could have accepted her homosexuality, she would not have become psychotic.

When the ego can no longer properly defend itself, the unconscious homosexuality threatens to emerge. In the unconscious, homosexuality is the equivalent of castration because both conditions preclude the continuance of the stream of life. When this homosexual attitude takes over, it constitutes the threat of imminent biological death. At this point, in the case of the patient just mentioned, her *imaginations* gained the force of reality. She became "The Holy Trinity," incorporating her masculinity, her femininity and her child. She dealt with the instinctual drives that seemed to threaten her life, in a well-known paranoid manner, by saying that the tempting devil was responsible for all within herself that she felt to be evil. As the Holy Trinity, she was safe from the devil.

The wish, then, became schizophrenic reality because the consequences, from the patient's point of view, would have been deadly were it not satisfied. To further illustrate this mechanism of self-preservation and at the same time to show the type of crude and jumbled productions from which the basic motivation must be extracted by the therapist, I shall present some actual case material.

Joan, twenty-five-year-old mother of two children, was brought to my office in an acute catatonic state. She had on a dirty housedress and sneakers and her long hair streamed untidily down her back. She was quiet only when she was preoccupied with some magical act; but, for the most part, she talked unceasingly in a rapid monotone, punctuated by gasps, tears and inappropriate laughter.

During the first few visits, I listened carefully to her productions and told her often that I was there to protect her and would allow her to do anything she wanted to do. She crawled through every door in my office suite on her hands and knees. Each time she did so, she would squat down and press her abdomen, as if to give birth or to evacuate the bowels. She said specifically several times while doing this, "I have to give birth to me." Once when I asked her if she was in pain, she replied, "Christ, you don't have pain when you have a baby anymore." On one occasion she tried to crawl through a tiny opening in one of the windows; when she was unable to do this, she thrust her long hair through the opening. All her efforts seemed to be concentrated on a desperate effort to be reborn. Each time she went through this symptomatic act, it was interpreted to her as, "You are trying to be born again. You would like to be a boy this time and maybe *then* your mother would love you."*

* The schizophrenic wish to be reborn is nothing new. Girls often try to be reborn into boys. One of my patients said, "Somebody sewed up my hole. I think the doctor

On the fifth day of therapy, I insisted for the first time that Joan stay in the treatment room with me. She stayed in the room, but when I asked her to lie down on the couch, she gave no indication that she had heard me. She wandered about the room gaily examining my books and furniture. Then, spying a cigarette on the table, she picked it up. When I said, "Drop the cigarette," very firmly, she dropped it on the floor and made a dash for the door. I grabbed her, pulled her back in again and forced her down on the couch. While I held her wrists, Joan squirmed, kicked and wrestled violently. She kept up a continuous stream of productions which indicated she was fantasying enormous sexual experiences. The struggle lasted adout half an hour and I made no interpretations until she had quieted down from sheer exhaustion. Very often at the end of this type of struggle the patient seems closer to reality.

P: *See saw, Marjorie Daw.* (Sings.) *Mother must get a new master.*
D: *Have you got one now?*
P: *Brother, you can say that again. Let him guess, he wants it. He threw it away, away, away, away. He threw it away, away, away. A minute, a moment. Girl, he broke my bones. I gave it the candle. You put it out. But it's out. Out. Out. Brief notes. Ooh, brief. Can this be brief?* (Hums.)
D: *Lie still and don't move.* (Patient lies on stomach and bounces up and down, groaning in the pillow.) *Stop it, Joan!*
P: *They don't know when the lights are out. I don't know when anything can possibly be worth such a bunch of crap.*
D: *Stay right where you are.*
P: *I don't know where I am. I am a little son out of the cunt. A.K. A.K. Break it again. In, in and out, in and out. That's what we don't see. We don't see it. Look at her arm.* (Gasps.) *Help, help, help, help, help. Pee. Oh, wait, brother, I have to pee. If not, on the floor. That's all obvious. Well, look how obvious that object is. Object. Who has to scratch it? Her cunt. Pee on the floor. On the floor. No, there is a dark well that doesn't come back. It doesn't come back. Nice little secretary, please.* (Appeals to secretary in wheedling tone.)
D: *She is only here to take notes.*
P: *You must imagine. Oh—you don't know what you can imagine in the dark, when you are so sick in the dark.*
D: *Are you going to lie still now or does the fight go on?*
P: *Yes, of course, if you will let me go. It wasn't worth it, was it?*
D: *No, it's better to lie down.*
P: *Oh, rest.* (Sighs.) *Where is that son? Where is that son?*
D: *Put your head on the pillow.*
P: *My head on the pillow.*
D: *Come on. No more fucking. Lie down. Put your head down here. Pull your skirt down.*

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did it when I had my baby and my pee comes out through a tube attached to my belly button." This phenomenon is by no means limited to women patients. Men seek to become reborn as women and, although I have had no such specific evidence as this in a male patient I always find a homosexual fixation with the father figure as the object and the father's penis as the breast.

The sexual experience that the patient has been enjoying is probably only a feeling of bodily motion, perhaps being lifted up by the mother or rocked in the cradle. At this level of regression, I doubt whether there is any conscious genital feeling indicated by her productions. I added, "No more fucking," which is an interpretation on the genital level, rather than, "No more rocking," in the hope of forcefully arousing the patient to more mature considerations. By the use of this word, I hoped to remind her of a genital experience she once had had, which during the schizophrenic state is amnestic. All postphallic level experiences constitute a period of amnesia for the schizophrenic patient, just as all prephallic experiences constitute an amnestic past for the neurotic.

I told Joan several times that I was going to protect her but that I also had to control her. I ordered her to lie still. She did finally and I asked her why she fought me when I loved her and protected her. She put her left thumb in her mouth and sucked it vigorously saying, "Ooh, that's good. That's wonderful. I want it again and again." Then she removed this thumb and sucked on her right thumb.

P: *Out, out. He says to take the thumb out. Take it out.*

D: *You have me mixed up with your mother. Did she tell you not to put your thumb in your mouth?* (Patient nods.) *Were you a thumb sucker as a baby?* (Patient nods.) *I don't mind if you suck your thumb.*

P: *Thank goodness.*

D: *That's all right. Don't bite it. You can keep it there as long as you want. It's all right. It's all right. Do you get pleasure from it?*

P: *Yes.*

D: *Is it very exciting?*

P: *Yes. Yes. Hard. Hard. Hard. Hard. I love them. Christ, I love cigarettes. Why doesn't someone give me a taste, a taste. I want my thumb. I want my thumb. I can't have my thumb. It's nice to suck a thumb. A baby can certainly suck a thumb with its mother.*

D: *I am your mother now and I will permit you to do whatever you want.*

P: (Sucks thumb vigorously, breathing deeply and regularly.)

When I said, "Drop the cigarette," the patient made a dash for the door like one in a panic. The cigarette is easily equated with the breast. In refusing it to the patient, I appear to the patient like the depriving mother must have appeared to the infant. The patient, enraged, then precipitates an enormous struggle, after which she seems closer to reality. I cannot go into the whole matter of schizophrenic aggression here because it is not the purpose of the paper to dwell on management of the patient. I will venture the following guess as to why it was necessary to win in this type of struggle with a patient.

The therapist is the forbidding parent. The patient hates the forbidding parent and wishes him dead. If the patient succeeds in this magical disposing of the forbidding parent, he himself is lost. Picture an infant at the breast level. Imagine it alone in the midst of a forest in deepest Africa. As

far as the neo-natal infant knows, this might well be so because there is no one other than himself and his breast-mother as yet in his object world. If the parent is destroyed, what will happen to the infant? I credit the infant's unconscious with being aware that if the parent is destroyed it will then die. Perhaps this is based on the talion principle, perhaps not. At any rate, it has been my experience that the therapist must win or the patient will lose.

"See-saw, Marjorie Daw," is an experience of swaying to and fro, familiar to every child. At this patient's level of regression it refers to infantile masturbation rather than to mature sexual intercourse because she talks about mother getting a master. The word "master" carries with it the idea of one who is on top. The age of the See-saw, Marjorie Daw contains a whole world of discovery which includes the experience of early masturbation and the search for a more specific anatomical knowledge of the genitals.

"Oh, throw it away, away, away," could be a castration wish. "I gave it the candle," is a description of a well-known masturbatory experience. The birth concept of the Marjorie Daw child results in what the patient soon talks about: i.e., "A bunch of crap," which is herself being born. And then she states, "I don't know where I am. I am a little son out of the cunt." "I am a little son . . ." clearly indicates that *her wish has gained the force of reality* and she now thinks of herself as a boy.

In connection with Joan's birth fantasies, it is well to pay heed to the teaching of psychoanalytic theory. From the experience of our analytic predecessors we learn that when a woman is giving birth, she unconsciously gains the equivalent of the longed for and hitherto absent penis.

Following the treatment up to this point, either because of the interpretations, the actual physical control of the patient's aggression, or because of other reasons unknown to me, her behavior changed. She was compliant and lay quietly on the couch. Her psychotic chatter no longer came in a steady stream and she was able to converse with the doctor on a realistic level for a few minutes at a time. She allowed herself to be dressed more appropriately by the nurse.

Her psychotic productions became less irrelevant and now related mainly to her lack of a penis and her confusion regarding her sex. She still spent a great deal of time acting out birth fantasies. I interpreted her symbolic remarks and acts and constantly affirmed her femininity by calling attention to all her attractive feminine qualities, even insisting that her female genitals were far more useful and desirable than a male's. On the twelfth day of treatment, she giggled and said, "Gee, I think I am a lady, sir. That feels swell. Did we cut them deep in the groove?" I replied, "Deep in the groove is your vagina. You have discovered that you are a woman."

The next day, when she was all dressed up, Joan asked me if I didn't

think she looked nice. Since she was calling my attention to her feminine attractions, I felt it was important to make a direct analytic response which would emphasize the desirability of being a woman rather than a man. "Imagine how sad it would be if you didn't have your beautiful vagina. Your vagina has great value. It produced your two children. That's something wonderful that could happen only inside of your wonderful body. How I wish I could make a baby inside of my body."

I could tell that Joan was impressed with my evaluation of her femininity because from that moment on, she ceased to give me the impression of clumsiness and heaviness. Her behavior became rather coy. She began to cross her legs and made obvious gestures of smoothing her clothes over her breasts and her hips to call my attention to these feminine virtues. There seemed to be no doubt that it did something to her pride in herself to know that I considered her an attractive woman.

Fifteen days after the start of treatment, Joan was well behaved and quiet. Her mind was still cloudy, however. She looked out of the window and wondered how it was that the city had been rebuilt so quickly. She remembered a short time back seeing it leveled to the ground. I told her that the city had not changed; she had changed. Then she spoke about her illness. She was under the impression that her eyes had been injured. She said at first, "Perhaps a change of glasses would straighten things out." (In the beginning of her illness she had seen strange things. She thought it was because of some visual defect, but I explained to her that whatever defect existed was to be found in her mind's eye. When she relinquished the psychosis and attained some judgment about reality, she resorted to a physical explanation of her illness and related it to an ocular abnormality. Many schizophrenics show this preoccupation with their eyes. Leaving aside for a moment what we know of the eyes in relation to castration, I would prefer to emphasize that a physical explanation provokes less anxiety than the psychological one and it is through this hypochondriacal trick, even in early schizophrenia, that dangerous conflict material is kept in repression.)

Joan went on during this session to talk about her husband and described an encounter with him when she had refused intercourse. They had had a violent physical struggle and she had won. I replied, "You can be certain that between you and me, you will not win. I will win." The patient answered, "I know that. We had our fight physically and mentally. You remind me of my step-grandfather." I answered (remembering the character of this man from the anamnesis), "I guess he broke your spirit by overcoming you and dominating you when you were a child. The difference between him and me is that I dominate you to protect you from harm because I love you."

The patient told me then that she didn't like me at all at first, but that she became convinced I was on her side because I gave up my lunch hours for her and because I called her up on the telephone and seemed really concerned. Joan continued, "This whole illness is one of losing time. I went back as far as I could, even to my earliest infancy."

So much for the psychotic part of her illness. From here on, there was little of it left to deal with. It was obvious that she was awake.

Later, when Joan was being treated by a more orthodox form of psychoanalysis, the pattern of her early life gradually became clearer. Let me sketch Joan's case history very briefly.

She had struggled all her life to conform to the impossible standards of a non-loving mother. Her mother demanded that she be pure, perfect in mind and body and without sexual instincts. Joan must have sensed her mother's hatred,* but, not understanding the hypocrisy of her mother's attitude, thought that if she could be all things that her mother wished her to be, she would be able to obtain her mother's love.

Her mother, she thought, loved her brother, who was three years her junior, and she observed that he was not forced to conform to the same rigid standards of behavior expected of her. The only difference she could see between her brother and herself was that he had a penis and she did not.

Joan's mother was unusually severe in regard to toilet training and infantile masturbation. Her mother had told her when she was a child of her father's disappointment that she was not a boy. In later years he displayed a disgust for her femininity that was almost pathological. As long as she could remember, her father would make her stand in the light before she left the house, to make sure that her undergarments and her dress concealed the space between her thighs. This experience, which was very embarrassing to her and very difficult for her to relate to me, undoubtedly reinforced her feeling of sexual inferiority.

In a paper on technique, Freud states that the hardest thing to resolve in a woman's development is her penis envy; the hardest thing to resolve in a man's development, his homosexuality. Since experience shows that it is so difficult for women to resolve their penis envy under ordinary circumstances, it is no wonder that Joan was unable to resolve hers with the added burden of constant parental assault.

While at college in her late 'teens, Joan broke away from her family completely and a short time later, went to live with the man who was later to become her husband. Joan enjoyed the masculine atmosphere of the university and prided herself on being considered "one of the boys" among her lover's bachelor friends. She was unaware that her being one of this bachelor group was related to her strong homosexual drives. This behavior

* Her mother's hatred was unconscious and the real reason for it, I believe, could be discovered only by analyzing the mother. The same is true of the father.

no longer stood up in the face of her increasing involvement with this man. Unwisely, she got him to marry her and later moved with him to another part of the country where she soon found herself in competition with the women in their new circle of friends. This she was also unprepared to deal with for the same reason that she was unprepared to be married at all. Her husband pursued other women openly, but she refused to believe that he was unfaithful until she had actually witnessed an amorous meeting between her husband and another woman. This incident precipitated her psychosis.

Joan's psychotic *imaginations* represent a heroic attempt to live, just as did the *imaginations* of the dying soldier in the desert. Joan's mother could love her only if she were a boy, and because of Joan's life-and-death need to be loved by mother, she sought to become a boy through symbolic rebirth. At Joan's infantile schizophrenic level, this meant, "Now mother will feed me and I won't die." If this need to obtain mother's love had not been so urgent, Joan would have experienced it simply as the thought, "I wish I had been born a boy, then mother would love me more." Only when the need is a matter of life and death is sufficient energy generated to make the *imagination* real.

In looking back over this case and others like it, we see that the ego is playing a little game of make believe. According to the mirage principle the function of the *imaginations* is to provide the patient with those things that are necessary to the continuance of life. All that I have been reporting here will make no sense if you think of the schizophrenic as an adult, because the adult is unconcerned about getting food from mother. He can go to the icebox and get his own food and he knows that. Considering the adult further, even if he commits incest with his mother he knows that no one will castrate him. Only if you believe that the schizophrenic is again an infant will you be able to understand the life and death meaning of the deprivations he magically replaces, whether they be the breast, the stool, the genital or anything else. The real parents failed to provide what it takes to insure proper development. If they had, it is my belief that the primary love objects could have been relinquished to the depths of the unconscious from whence they would not again have appeared in consciousness.

I will not attempt to bring out why the parents were unable to carry out their role satisfactorily, although I know that the answer to this question has far-reaching consequences. It makes clear, however, what the role of the therapist must be. Utilizing the transference and counter-transference you become the patient's parent and the patient becomes your child. The patient is re-living the infantile period and you are afforded the opportunity of bringing him up all over again. In the productions you can discern

what the patient wants. With words, deeds and instinctual feelings you can replace the deficiencies that were experienced in the first place. My recovered patients tell me that I do this. I wish I could say exactly how and perhaps I will be able to in time.

Conclusion

I think I should make it perfectly clear that what I have said about schizophrenic *imaginations* in this paper is just one of the many aspects of the problem being studied. I think it explains an important, but small part indeed. As yet we are unable to explain and are studying intensely such problems as why the libido is detached from present reality and reattached to the reality of the infantile period. Further, why does the schizophrenic regress to various levels of infancy and revert to the psychosexual development of those levels? When they soil and wet, what has happened to the toilet training? Where does speech go in the mute catatonic? I mention just a few of the questions to be answered. All this seems for the moment divorced from what I have been discussing about schizophrenic *imaginations*.

The treatment of deteriorated schizophrenia affords one an additional avenue for the study of the unconscious. We are determined to pursue this study relentlessly until, stage by stage, we gain clearer understanding.

INTERIM REPORT OF THE RESEARCH PROJECT ON THE SELECTION OF MEDICAL MEN FOR PSYCHIATRIC TRAINING*

By LESTER B. LUBORSKY, Ph.D.,† ROBERT R. HOLT, Ph.D.,† and WILLIAM R. MORROW, Ph.D.††

Three years ago a special issue of this *Bulletin* presented a preliminary description of the selection research under way at the Menninger School of Psychiatry, along with a general description of the new School, its philosophy, curriculum, etc.[1] Since that time, a good deal of headway has been made with the research, and it seems high time for another report of work in progress. By now the general design of the investigation has been well crystallized, all of the subjects have been assessed, and some preliminary results have been obtained which support an optimistic view of the ultimate outcome. It must be emphasized, however, that we shall not be able to make a final evaluation of our work for another three years. Meanwhile, here is an account of the background of the project, its aims, and plans, and a synopsis of work completed to date.

Background. After World War II, when relatively little experience had been accumulated with the problem of selecting potential psychiatrists, psychiatric training centers were overwhelmed for awhile by applicants. (Many doctors had discovered in their military experience both the tremendous social need for psychiatric care and some of the possibilities of service in this field.) Since that time, the flood of applicants has abated, but a considerable problem of selection has remained. No matter how few the applicants, it will always be necessary that the profession of psychiatry select its practitioners carefully, in order to avoid the social and personal waste and even tragedy that may result from the interaction of emotionally ill patients and unsuitable would-be psychiatrists, either during training or afterwards. In psychiatry, more than in other branches of medicine, both doctor and patient may suffer from such an encounter.

When the Menninger School of Psychiatry (hereafter referred to as the MSP) was founded, a plan was developed to select residents in the most effective way then possible, and at the same time carry on research into the problem. As research, it consisted of applying available methods of assessment, making predictions based on them, and seeing how well the predic-

* Supported by a grant from the Veterans Administration, through the Committee on Veterans' Medical Problems of the National Research Council. Gratitude is expressed to the Veterans Administration for its assistance to this research project.

† Research Department of The Menninger Foundation.

†† Department of Psychology, Western Reserve University.

tions were borne out. The project's present design evolved slowly during the period of the school's first two years. The MSP made an ideal setting in which to develop such research, being the country's largest psychiatric training institution, with about a hundred residents at a time under the supervision of an integrated faculty. With so many men receiving approximately the same training, groups large enough for statistical purposes could be studied without prolonging the project unduly.

In the latter part of 1947 and early in 1948, a full-time research staff* started work on the project and developed the final experimental design in collaboration with the Director of the Research Department: originally Dr. David Rapaport; since August 1948, Dr. Sibylle Escalona.†

Aims. The primary objective of the project was a practical one: to find out the best ways of selecting physicians for psychiatric training who will be able to complete such training successfully. There are three main parts to this goal: finding *what to look for*—the qualities of personality that distinguish candidates who will make best use of training from those who will not profit as much; finding out *what instruments to use*—the methods of interviewing and testing that will give the best measures of these crucial qualities; finding out *how to use these instruments*—the specific methods of analyzing the data so as to extract from them the maximum relevant information, with the greatest amount of agreement between different evaluators.

* The authors have comprised this staff since 1947. The period of Dr. Morrow's most active participation was from March 1948 to September 1949; he will continue to participate in certain parts of the project.

† A number of other psychologists have assisted with various parts of the work: Mr. C. V. Ramana, a psychoanalyst from India in this country on a research fellowship, spent half-time on the project from January to August 1948; Mr. Martin Mayman worked part time on some aspects of the project during 1946 and 1947; Miss Glenna Webster has played an important role in the project as a research assistant from July 1949 to the present. Special mention should be made of the contribution of Mr. Walter Kass, who has spent an increasing amount of time during 1949 in working on the development and cross-validation of a method for analyzing the Rorschach test for the selection of psychiatrists. Dr. Donald Marquis gave valuable help in a thorough examination of the experimental design in its later stages. Since the project began, we have profited from the exchange of information with the University of Michigan project on the Selection of Clinical Psychologists. Among the psychiatric consultants whose advice has been helpful are: Dr. Robert P. Knight, Dr. Karl A. Menninger, Dr. Jan Frank, Dr. Merton Gill, Dr. Lewis L. Robbins, and Dr. Robert L. Worthington, of the Menninger Foundation; Dr. John Whitehorn of Johns Hopkins; Dr. James G. Miller, Chief Psychologist of the Central VA Office at the time; and Dr. Jesse F. Casey, Manager, Winter VA Hospital. In addition, we owe a heavy debt of thanks to a large number of other psychiatric colleagues who have provided criterion evaluations, and above all, to the approximately 500 physicians who have been our cooperative and very helpful subjects.

Other aims of scientific rather than immediately practical importance have been added within the research framework. The chief one is to make a systematic study of the evaluative processes in the clinical analysis of complex psychological data, so as to highlight those which lead to the most valid conclusions. Attaining this objective will help insure that our results will be repeatable (or even improved upon) by others, but it will also be an important contribution to the objectification of clinical psychological methods. We intend also to contribute to the understanding of the nature of psychotherapeutic ability, to investigate the effects of psychiatric training on the personalities of residents, and to explore some of the psychological and sociological determinants of occupational choice and occupational adjustment, particularly for psychiatry. This last involves a study of stated motives for entering psychiatry, the related personality qualities, and the background characteristics of applicants.

Synopsis of Work to Date, with Preliminary Results

The work of the project can be listed in a number of distinct steps; they are in roughly chronological order.

Step 1. Trying out assessment procedures which seemed promising for predicting later psychiatric performance.

At the outset, the School had set up as good a procedure for choosing residents as possible; considerations of research were secondary. It was decided that each candidate should have three separate psychiatric interviews and a battery of psychological tests. The interviewers were free to use whatever style was most congenial to them and to cover any areas they wished. After about an hour's conversation, the interviewer filled out a form which listed a number of topics for inquiry and observation. He then made a predictive rating of the candidate's overall capacity as a psychiatrist, on a scale from 1 (completely inadequate) to 10 (outstandingly excellent). The interviewer also wrote a brief evaluative statement on the back of the form.

The Wechsler-Bellevue, Rorschach, Word Association and Szondi tests were administered and evaluated as a battery by a psychologist, who wrote up a brief statement of the relevant findings and made a predictive rating on the same scale as that used by the interviewers. The decision to accept or reject was made by the Admissions Committee of the MSP on the basis of the interview and test reports.

When the Project started, these data were turned over to us. Project members have at no time participated in the actual choice of residents nor in any other decisions about them. All other research data have been gathered by the Project members and have been kept entirely confidential—a fact which the subjects are told, so that they know that participation in the research can not in any way affect their careers in the MSP or subsequently.

The Project has found out some interesting facts about these initial assessment procedures: that there was only slight agreement between the predictions based on the tests and those based on the interviews; that the interviewers agreed well with each other; and that both the test and interview ratings distinguished poorly between those accepted and those rejected. The last finding points to the fact that the decisions of the Admissions Committee were often based on considerations other than the ratings which had been given. For this reason and because, as is shown below, the original techniques of assessment lacked high validity, there remains in the group of accepted residents who form our principal research population, a wide range of fitness.

Step 2. Developing acceptable standards (*criterion measures*) of the quality of psychiatric performance, to see how the initial predictions turned out.

One of the first tasks of the research team was to try out the most easily available criterion measure: evaluations of each resident's work made by clinical supervisors at a late stage in his training. Fourteen supervisors were interviewed and asked for evaluations, but the actual number of raters for each resident averaged between six and eight since no supervisor could have contact with all residents. Each evaluator rated only those men whose work he felt competent to judge, making qualitative statements about good and poor features of a resident's work, and rating him on a four-point scale of overall psychiatric proficiency. At the same time, in a sociometric test, each resident was asked to choose the three members of his group whom he considered to be the best all-around psychiatrists, the three best neurologists, the three best potential psychoanalysts, etc. For convenience, these are spoken of as "peers' evaluations."

We found that the initial test and interview ratings predicted the peers' and the supervisors' evaluations of psychiatric work rather poorly. The correlations between predictions and criteria were large enough (around .2) to indicate statistically that the predictions were better than chance, but not large enough to be of much use for selection.

Step 3. Discovering sources of error in initial predictions through an intensive analysis of cases who were markedly over- and under-estimated.

Our next job was to find out the sources of error and ways in which we could improve on these results. One method was to examine the original reports on persons who were most over-estimated or under-estimated by the predictive ratings. From an analysis of the over-estimated cases it was clear, for example, that an appearance of maturity, poise and dignity made too good an impression on most raters. On the other side, there was some evidence that a direct display of hostility by the candidate caused him to be generally under-estimated to an unwarranted extent.

Step 4. Discovering what attributes to look for, by consulting the opinions of experts about qualifications and disqualifications for the practice of psychiatry.

One source of faulty predictions had been found to be ignorance of what specific aspects of personality were relevant to the job. The previous step had suggested some hypotheses; others were sought by collecting the opinions of psychiatrists who had had long experience with specialty training.* We pooled the lists of attributes they suggested and boiled them down to a set of 25, including such qualities as: Integrity, Emotional Stability, Emotional Warmth, Objectivity Toward Others, and Psychological Mindedness.

Step 5. Collecting or devising assessment procedures which would be likely to cover those attributes most essential for psychiatric work.

Our list made it evident that several important areas were not being adequately surveyed by the procedures already in use. We compiled a new battery including two different interviews administered by the experimenters, an autobiography, and ten tests, most of them original.

Step 6. Assessing a small sample of residents, using the new procedures, to find which were related to psychiatric proficiency.

We selected a pilot group of subjects (called the Small Sample) to represent a complete range of the kind of psychiatric aptitude that we were looking for. Using supervisors' ratings (Step 2.) of the hundred or more men who had been in the residency program a year and a half or more, we picked out and assessed about thirty men, who had received ratings from the bottom through the middle to the top of the scale. Our analysis was primarily focussed on the ten who received the highest and the ten with the lowest ratings ("Highs" and "Lows"). Seven sources of data were chosen as worthy of further study, on the basis of their discrimination between Highs and Lows, and their practicality for a selection program. These are: Application Credentials, a recorded structured interview, the Thematic Apperception Test (TAT), Self-interpretation of the TAT,** Rorschach Test, Picture Reaction Test,† and Strong Vocational Interest Blank.

* We were fortunate in having available the results of a survey conducted in 1945 and 1946 by Dr. Robert P. Knight, in which 32 training psychoanalysts set down the fruits of their experience in the task of selection. Other documentary materials consulted were an article by Dr. Hanns Sachs,[2] the report of a committee headed by Dr. David Shakow,[3] and an unpublished systematic list by Dr. Henry A. Murray.

** A new procedure devised by L. B. Luborsky on the basis of a suggestion by Bettelheim.[4]

† A new procedure devised by R. R. Holt.

Step 7. Preparing manuals to guide the scoring of the most promising procedures and the making of predictive ratings.

A step of crucial importance is the preparation of empirically based manuals leading to the interpretations most relevant to predicting success in psychiatry. Only in this way is it possible to have different people examine the same material and reach approximately the same predictive judgments. In deriving the manuals, we made use of all the various kinds of differences (or "cues") between Highs and Lows, and to some extent differences between Lows and Middles. We had to draw on our clinical experience and relevant findings in the literature to guide us in deciding what personality variable was operating to bring about the appearance of any differentiating cue. This analysis of the Small Sample gave us an empirical basis for revising the list of personality variables ("what to look for"). The end result was a list of 32 concepts under which almost all of the differentiating cues from the Small Sample cases could be subsumed.

Each manual includes: a statement defining each cue; quotations of illustrative material for each cue; an indication of the relative weight to be given to each cue; some principles of "pattern" analysis telling how to evaluate certain combinations of cues which have special significance; and the personality variable which each one usually implies. At present these manuals are in experimental form; when finally revised (Step 8) they are intended for the use of persons who are actually engaged in selection.

Step 8. Putting our manuals to the test by using them to predict success in the residency training program.

As they stand, our manuals differentiate well between the known Highs and Lows. This fact tells little about how they might do on an unknown group. It is therefore necessary to carry out the step called "cross-validation": using the manuals with a new group to predict the criterion of success or failure in the School. The project is now engaged in carrying out this step. Two new classes (about 65 residents) have been given the new tests and interviews in addition to the old ones; we are now beginning the analysis of data for this final major validation study for all procedures. Our objectives in this final study are: a) to choose the most efficient battery of selection procedures, b) to refine and validate the manuals, c) to obtain checks on reliability of scoring for each manual, d) to obtain personality ratings having the highest degree of validity, to be used later on to test our hypotheses about qualities a man should have to profit from residency training, and e) to make possible a study of the processes by which data are analyzed.

This last point requires amplification. If, for example, there should be any large discrepancy between the validities of ratings made by two ex-

perimenters on the basis of the same battery of procedures and using the same manuals, it would be clear that one was using the manuals differently and more effectively than the other. But if both raters had recorded the processes they had used in arriving at their judgments, it would be possible later to discover and point out errors into which one had fallen and make available the valid methods used by the other.

At the same time a study of the processes of analysis has considerable scientific importance. Clinicians have long felt that the complex qualitative materials obtained in interviews and projective tests are the most useful for their understanding and prediction of behavior, yet many predictive studies using data of this kind have given poor results. The difficulty besetting such studies may well lie in the area of scoring and interpretation, rather than in inherent shortcomings of the methods. Our approach is to attempt to clarify and specify our clinical interpretative efforts: first (on the side of analysis), by discovering the significant cues on which correct interpretations are based; and second (on the side of synthesis) recording the processes of weighing and judging evidence in reaching complex conclusions about personality so that these processes may be studied when the validity of the predictions has been determined.

Some promising results have already been obtained from preliminary cross-validations on an earlier class of residents. The TAT had been given to a group of 34 men on whom criterion ratings were available after one year of training; it yielded the best predictive result yet obtained. The total score for the TAT manual correlated .60* with supervisors' ratings of overall psychiatric proficiency, .61 with similar ratings of psychotherapeutic ability. By way of comparison, the average predictive rating given by psychiatric interviewers to the same MSP candidates correlated .24 with the "overall" criterion, and the ratings based on the standard battery of tests (analyzed without benefit of manuals) correlated only .14. In concrete terms, these figures mean that it would have been possible to have set a "cutting point" (that is, a score below which all candidates are rejected) from the TAT alone which would have screened out *all* those whose performance was later unsatisfactory along with *only one* other resident, whose work was judged to be about average. If a cutting point were established for average interviewers' predictive ratings so that, similarly, everyone who turned out poorly would have been eliminated, *19 acceptable residents* would have been rejected along with them, including 7 of the 13 best men in the class! This comparison shows the kind of improvement in selection that we may hope for as a result of the research.

* A correlation coefficient is a statistical expression of the degree to which two sets of figures vary together. Correlations range from zero (no relationship) to 1.00 (perfect correspondence); a correlation of .60 means that there is a fairly high degree of association.

On the basis of this first set of results, the manual will be revised by means of an analysis of the sources of errors; the revision will be used in the final cross-validation. Profiting by our mistakes and improving the criterion measure may lead to even better success in prediction.

The Nature of the Criterion of Success

No predictive study is any better than its criterion measure: the standard against which all predictions must be judged. Ideally, we should like to have a true measure of a man's final worth as a psychiatrist; practically, we recognize that such a measure is unobtainable. It is more feasible to get a measure of *success as a psychiatric resident*, and our sights are accordingly trained upon this target.

The choice of specific measures basically depends on the judgment by members of the profession about what constitutes success. It is not the function of a research team to make up the definition of professional competence as a psychiatric resident, but to formulate specific measures of it that are scientifically usable while retaining the essence of the standards set by the profession itself. No single measure can suffice. Certain basic criteria are obvious: Does a man complete psychiatric training? Does he establish a psychiatric practice? Does he obtain the diploma of the American Board of Psychiatry? These are questions which are relatively objective, and the answers to them may be obtained through mailed questionnaires. So far we have had exceptionally fine cooperation from our subjects in returning the annual questionnaires we have sent them to obtain these and similar data about their work. A recent tabulation of returns showed that completed forms had been received from 95% of alumni, 85% of candidates who had withdrawn application, and 55% of candidates who had not been accepted into the School.

In order to make finer distinctions between those in the great majority who will establish psychiatric practices, we are relying on two types of measures. On the one hand, we shall soon start applying "work-sample" methods, involving direct evaluations of diagnostic and psychotherapeutic work. On the other, we shall continue to rely mainly on the judgments of psychiatrists by other psychiatrists: their peers, and especially their supervisors, who have close contact with their actual psychiatric work. Similar judgments form the bases on which people are hired and obtain advancement. Because of their qualifications and their opportunities to evaluate the residents, the supervisors' judgments have the highest degree of direct or "face" validity; they form our principal criterion measure.

After a few years of experience in obtaining such judgments, we feel that we have learned a good deal about ways to obtain the most useful ratings. For example, we found that we get a more useful work evaluation

by asking for a confidential statement for our project, than by taking the official rating submitted to the School offices by the same faculty members. In this way, because they know that all data in our files are kept completely confidential, the supervisors can speak out frankly and tell all that they know about a man's work without the fear that it may have an unfortunate and unwarranted effect on his later career.

Some of the facts that tell us it is a good criterion are the following: a) The supervisors agree quite well among themselves about the ratings given to each resident; b) the ratings show high consistency from one set of evaluations to a later one; c) the supervisors' qualitative statements show that they share common standards for evaluating psychiatric work, and that these standards are meaningful in terms of modern dynamic psychiatry.

For example, a frequently given basis of judgment, which might be titled "ability to establish good relationships with patients," consists of such statements as: "his patients all like him," vs. "his patients ask to be transferred to another doctor" or "don't trust him." Another basis, which might be titled "emphatic objectivity vs. overidentification," consists of such statements as: "able to empathize with patients without becoming too emotionally involved," "maintains neutral friendly attitude toward psychotics," vs. "oversympathetic and coddles patients in whom he sees himself." It is important in understanding the total research results to know that the supervisors' opinions about a man's overall excellence as a psychiatrist were most heavily determined by their judgments of his psychotherapeutic ability. Our Highs therefore were outstanding in this ability, while some of the Lows were doing adequately in other work functions but were considered poor psychotherapists.

Plans. Ideally, it would be desirable to continue the project for several years more, so that the residents in the final predictive study might have a chance to show their mettle in actual practice. A number of considerations urge, however, that the project be brought to a close by the middle of 1953. Provided that financial support is available, the next three years will be devoted to intensive analyses of our data, the collection of criterion measures, and the preparation of final published accounts of various aspects of the work. In all publications, group results only will be reported, and no subjects will be personally identified in any way.

Meanwhile, the project will make available the successive revisions of our manuals to the MSP and to other training institutions that would like to try them, along with appropriate cautions about their as yet tentative nature. It seems very unlikely that the present research, even in its final stages, will provide definitive answers to all of the knotty questions involved in selecting physicians for specialized training in a changing and

growing profession, but we do have grounds to trust that it will suggest ways to make selection easier on both applicant and institution and at the same time appreciably more accurate.

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THE KANSAS BOYS' INDUSTRIAL SCHOOL TREATMENT PROGRAM

By RALPH W. COLTHARP, M.D.* and GEORGE H. WEBER, M.A.†

The Kansas Boys' Industrial School (hereinafter referred to as KBIS) is a public institution for the care of dependent, neglected and delinquent boys. The maximum age of boys at commitment by the various juvenile courts is sixteen; however, there is no selective intake. The average population is around 150 students; the average time in residence is from 9 to 15 months.

The KBIS was established on March 14, 1879, as a "State Reform School." Its history, like the history of many institutions of its kind, has at many times been turbulent; at other times, relatively smooth, but it has been ever changing and always exciting. Constructive treatment of the boys sometimes accompanied these periods, while at other times destructive and damaging treatment occurred. These various periods in the school's history were largely shaped by the implementation of the different staffs' principles or philosophies. Also contributing to the nature of these different periods was the quantity and quality of financial and community support, and the availability and selection of qualified personnel.

Perhaps as many philosophies have guided the establishment of programs at KBIS as there have been theories about the causes of delinquency. For example, there have been numerous educational programs, both academic and vocational, work programs, programs with religious emphasis, programs in which physical rehabilitation was stressed, military programs, and restrictive punitive programs closely resembling the "typical" penitentiary system.

From these various programs and similar efforts elsewhere, it appears that a more holistic approach to the treatment of delinquents has evolved. The current progressive school administration, with the aid of some new and trained personnel, has established a modern treatment program.

Aspects of Treatment at KBIS

The aim of this treatment program is to provide an environment in which a disturbed boy may receive help where he needs it, be it in educational, medical, sociological or psychological areas. It operates essentially in open buildings and only rarely are doors locked. Although it is believed

* Psychiatrist, Director of Clinical Services, KBIS, former Fellow, Menninger Foundation School of Psychiatry, Topeka, Kansas.

† Psychologist, KBIS, former Psychological Interne, Menninger Foundation School of Clinical Psychology, Topeka, Kansas.

that one should be as definite as possible with the student in regard to his length of stay at KBIS, the staff believes that a student should remain until a maximum therapeutic benefit is reached, or until satisfactory home conditions are established, rather than being sentenced for a definite period of time to pay a penalty. The staff is encouraged to feel that each person participates in the rehabilitation of the boy. Within the academic setting, special attention is given to those of borderline intelligence, and to those who are retarded because of emotional conflict.

It is estimated that 15 to 20 per cent of the students are in need of intensive psychotherapy. The majority of the counseling and psychotherapy is carried on by the social service workers, a psychologist and a psychiatrist. They are supervised by their respective case supervisor, the KBIS psychiatrist, or by a staff member of the Menninger Foundation. Some students are treated as outpatients at the Children's Division of the Menninger Foundation. A special unit for disturbed boys has been initiated. In addition to a comprehensive recreational program in which the group cooperation and spirit is emphasized, modified group therapy has been started. The groups are composed of aggressive, withdrawn and enuretic boys.

Staff Education

Since the staff at KBIS is composed of people from different backgrounds, training and experience, the need for staff education has become apparent. In order to achieve the treatment aims, a staff education program has been initiated which includes all personnel who come in contact with the boys. Within the school, the psychiatrist meets at intervals of once a week or more frequently with the teachers, cottage parents, and social workers. Within these groups, problems of practical and theoretical significance are discussed.

In addition to education within the school, it is the policy to send professional personnel to conventions and meetings in their respective fields. Staff members, including cottage parents, are sent to other institutions to study practical problems. We have obtained consultation from the Children's Division of the Menninger Foundation, and one or sometimes two Fellows from the Menninger School of Psychiatry are assigned half-time to the KBIS for training. The staff, insofar as possible, takes part in forums, seminars, and case conferences at Winter Veterans Administration Hospital and Children's Division of the Menninger Foundation.

Agency Relationships

We also have a working relationship with the Kansas Department of Child Welfare, the Capper Foundation and the University of Kansas. The Kansas Department of Child Welfare assists in obtaining case history

material and cooperates in the placement and supervision of some of the students. This department also has provided the school with two social workers. The Capper Foundation has provided speech therapy for some of the boys. The University of Kansas uses KBIS as a field placement center for student social workers. The American Legion and Kiwanis Club provide some recreation; the latter organization also sponsors a Boy Scout troop. The local churches provide both on and off campus church activities for the boys.

Application of the Clinical Services

A boy during his period of residency participates in a number of closely related diagnostic and treatment processes designed to make his treatment program unified and continuous.

Upon admission, a new boy is met by a social worker who seeks to allay any fears which he may have about the institution and describes to him the routine he may anticipate during his stay at the school, the opportunities offered by the school and some of its broad policies which are of interest to the boy. The social worker during this interview attempts to determine his temporary group placement, which is made on the basis of social, psychological and physical maturity.

Within the first two weeks after admission, the boy is given a temporary educational and vocational assignment by the vocational director on the basis of interviews, educational and vocational testing, school transcript and social history. During the next six weeks the boy is observed by the cottage personnel and receives a more complete educational and vocational appraisal, a social case history study, a physical examination and a psychological and psychiatric evaluation. At the end of these six weeks, a staff conference is held and the staff members concerned discuss the factors which have contributed to the boy's problems and decide on treatment measures. Based on these findings, the treatment considerations usually include counseling and psychotherapy, medical corrective measures, educational and vocational objectives, recreational participation and tentative plans for his return to home and community. Staff attitudes toward the boy are agreed upon and special precautionary measures are outlined, if necessary. In order to insure the utmost cooperation, the boy participates in this planning process. These bilateral staff-boy decisions are summarized and distributed to the individuals who teach, supervise or have any close associations with the boy.

If the boy displays erratic behavior or has an emotional disturbance, an adjustment committee, comprised of the people who are most closely associated with the boy, meets in an effort to determine some of the factors

which might be involved and tries to arrive at a suitable decision for solution of the problem.

At the end of the boy's seventh month in the institution, his progress is evaluated in the emotional, social and educational spheres. If he has progressed enough to adjust to home (natural, boarding, foster) and community life, a parole is recommended. Cooperative parole planning is carried on with the Kansas Department of Child Welfare and the Juvenile Court. If it appears that the boy's progress has been unsatisfactory, further institutional plans are made with the boy.

A case report exemplifying some of the techniques described in this paper is presented in the case of Tom. This case report is not intended to demonstrate a special technique for treating a particular "type" of maladjusted delinquent but to show how services are coordinated.

Case Report

Tom was a moderately tall, very slender, negro boy, fifteen years of age, who was sent to KBIS from a slum area of a large city in Kansas. He was committed to the institution for a break-in attempt. Tom's court record also showed that he had other difficulties to a marked degree. These difficulties included lying, disobedience, temper tantrums, excessive fighting, disrupting school behavior, truancy, running away from home and stealing.

Upon admission to KBIS, he was interviewed by the admissions social worker who found him generally guarded and evasive. He appeared to be timid yet hesitatingly friendly and superficially cooperative. He listened attentively to the routine orientation procedure and requested some clarification regarding the rules and policies of the school. Tom was placed temporarily in Cottage A, headed by friendly, accepting cottage parents, and consisting of a group of boys, the majority of whom were chronologically younger than himself but who, emotionally, were generally at Tom's level of functioning.

Approximately a week after admission, Tom was given a battery of educational achievement, aptitude and intelligence tests. With the exception of a few subjects, he was found to be educationally retarded, yet of average intelligence, with high mechanical aptitude. He was placed in an ungraded room for remedial instruction in those courses in which he was retarded and at his regular grade level for those subjects in which he showed no retardation. Expressing an interest in woodworking and carpentry, Tom was assigned to the carpentry shop for on-the-job training. He enrolled in a cabinetmaking course.

Six weeks after Tom was admitted to the school, a staff meeting was held in an effort to understand some of his problems and outline a course of treatment.

The social worker presented case history material which offered some insight into the problem. He related that Tom was born out of wedlock to a highly unstable, sexually delinquent mother and to a father who was a relatively "well-behaved" college student. This couple never married. The mother abandoned the child when he was six months old, at which time the paternal grandmother accepted him. Nine years later Tom and his grandmother joined the father because of financial difficulties. The father in the meantime had married a widow with a daughter approximately the

same age as Tom. Tom and his grandmother were not welcome in this household and although Tom had been somewhat of a behavior problem previously, he now became openly defiant, rebellious and aggressive toward this family unit. Various methods of punishment were used by the father, all without avail. With this difficult home situation, Tom began spending more and more time away from home, became unmanageable in the school and frequently truant. Shoplifting was his next step and he was finally caught attempting a break-in.

The psychological and psychiatric examinations indicated a severe emotional maladjustment in an adolescent boy. Tom was found to have an extremely low threshold for frustration with a characteristic rigid tendency to forestall, minimize or otherwise avoid anxiety-arousing situations. Intense underlying hostility was present with inadequate and weak mechanisms for its constructive expression. This pent-up hostility and extremely low threshold for frustration, along with anxiety, oversensitiveness, intolerant demands for immediate gratification and a great potentiality for impulsive motor discharge appeared to form at least a partial setting for emotional outbursts. Tom had difficulty in forming object attachments yet showed a strong need for adult attention and emotional support. Impaired "reality testing" and a tendency to withdraw into a world of fantasy were evident.

The cottage parents reported that Tom withdrew from group activities and had occasional temper tantrums. The educational and vocational findings were essentially the same as mentioned earlier.

The physical examination was primarily negative.

Recommendations

Upon the basis of these findings, the following course of treatment was outlined:

General Staff Attitude: Friendly acceptance.

Educational: Academic courses on his present level of intellectual functioning and educational achievement. Vocational training in cabinetmaking and carpentry.

Psychological: Assignment to a counselor who, under supervision, would see the boy regularly. Encourage group recreational participation as well as group life in general.

Social: Investigate possibility of a boarding home placement.

Length of stay: Re-evaluation at seven months.

The Course of Treatment in the School

Tom was seen five times a week for interviews over a period of two months and then was seen three times a week for approximately three months. Soon after Tom felt the security of the school and the acceptance of the counselor, he began expressing verbally as well as physically his emotional maladjustment. His stormy behavior brought about many difficulties and at times, daily conferences among the people who were working with him were required. Observations and efforts to understand his behavior, special handling techniques, staff encouragement and support, readjustment of schedules, e.g. educational and cottage, were the problems about which most of the discussions revolved. After several months of this stormy behavior, Tom made some effort to cooperate with the other boys and adults of his associations and became more regular and consistent in his activities. This progress of Tom's, though forward moving, was very irregular in that there were times when his old patterns of behavior returned.

Then, unexpectedly, the whereabouts of Tom's mother, which had been unknown since he was six months old, became known to him. Initially this revived his feelings of intense rejection and neglect but he was able to work through some of them. Tom's great desire to be wanted and to be loved and the mother's desire to have him come and live in her home (she had married) made further profitable residence at the school questionable. At the request of KBIS, the Kansas Child Welfare Division, with its out-of-state placement services, requested that a study be made of the mother's home with respect to its suitability for the placement of Tom. This report was favorable and Tom was released from the school to live with his mother. Supervisory services were arranged with a local agency by the Kansas Child Welfare Division.

Summary and Prospect

Perhaps the problems presented by this institution are no different from those posed by similar institutions elsewhere. They stem from the general lack of definitely established therapeutic principles and techniques in the whole area of delinquency treatment, the absence of selective intake, the lack of adequately trained personnel, inadequate physical facilities, loosely knit school-community parole planning and the lack of field supervision for parolees. Measures have been instituted by the State of Kansas and KBIS to solve these problems. A moderate building program has been initiated, funds have been made available for the hiring of more staff, a staff selection and staff education program are being carried on by the school. Coordination with other social agencies has been started. Finally, several research projects are being organized which may shed some light on the local problems as well as on delinquency generally.

CORONARY OCCLUSION IN RELATION TO AMBITIOUS STRIVINGS*

A Case Report†

By HOWARD WILLIAMS, M.D.††

A 41-year-old, white, unmarried fireman and mechanic was admitted to the hospital in November 1949 because of anginal attacks of ten months' duration. Recently, he had also had episodes of anxiety and feelings of depression and irritability and had been tempted to pick fights "in hope" of someone's killing him.

History: The patient was the second of four children and the only boy. As the boy of the family, he was expected to take care of the girls and to help provide for their education. Except for enuresis to his eighth year, he denied childhood nervous traits. He made good grades easily. But despite his intention to finish high school, he quit just before graduating in order to make more money than he was able to earn after school hours. This he did in order to help the younger children continue in school.

He worked at a variety of hard and often menial jobs, finally becoming a skilled mechanic. He was proud of his ability to stand adversity and to do excellent work without supervision. He quit several jobs, however, when he had to compete with fellow workers or to assume authority over them. At 34, he enlisted in the Army with the stated purpose of doing his duty for his "sisters and country."

His first symptom, that of backache, began after an officer had criticized him for not handling his men with more discipline. As a sergeant, he felt the men would resent his correcting them, and rather than face the hostility of both superiors and subordinates, he asked for a demotion. He continued to resent people in authority, felt he could be a better officer than they, and silently cursed superiors while acting with careful obedience. In this situation he suffered a minor accident to his back, followed by a mild urethral discharge. He became anxious, tense and preoccupied with backache. He attended sick call often, requested transfer, and was finally put on limited duty. He began to feel well in a job where he worked alone with considerable independence and without responsibility to any immediate superior.

After he was discharged from the Army at the end of the War, he took

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† From the Psychosomatic Section, Winter V.A. Hospital, Topeka, Kansas. Sidney Rubin, M.D., Director.

†† Resident, Menninger School of Psychiatry, Topeka, Kansas.

a job as a fireman. Despite light duty, he felt too much responsibility was placed on him; and when he was retained at a time when others were being let go, he again became acutely uncomfortable, with the feeling that the men under him resented his position. His request for transfer to another fire station was refused, and he felt trapped. Two days later he had a sudden severe chest pain and was sent to a private hospital. A coronary occlusion was shown by electrocardiogram.

When he left the hospital, he found he had lost his job. Then his application for a pension was rejected. He became depressed, began to drink excessively, and picked fights while drinking, with the expressed hope that someone would kill him. He suffered from recurrent attacks of pain and a sense of heaviness in the left shoulder. This symptom came on after varying amounts of exercise and was relieved by nitroglycerine tablets.

Ten months after his original heart attack, he entered Winter VA Hospital.

Psychiatric Examination: The patient, at the time of his admission, was a suspicious, tense, restless, sombre appearing man. He saw no connection between his feelings of suspicious resentment and his nervousness or chest pain. He was rational, coherent and above average in intelligence: but he continued to blame his employers for his condition ("they neglected me") and refused to consider his problem other than physical.

He described his father in respectful terms as a strict, hard-working disciplinarian, expecting dutiful obedience from his children without complaint. The mother he described as "a wonderful person," who encouraged a Spartan attitude toward life, an attitude he thinks he has always followed. In speaking of his mother's death, he wept, could scarcely speak, and took several tablets for the relief of sudden pain over his heart.

He thought he had made an excellent adjustment in life. He said he had a particularly high regard for women, but he was scornful and demanding of the ward nurses. He tried to maintain an appearance of friendly, almost jocular politeness, but this pretense quickly disappeared at any lack of attention, real or fancied.

Physical and Laboratory Examination (Dr. David Goldenberg, Medical Staff): Physical examination showed a robust man of stocky, square physique and ruddy complexion. There was slight enlargement of the heart to the left. Some of the retinal vessels were narrowed, with arteriovenous constriction. However, the blood pressure did not rise above 130/85. An electrocardiogram indicated a bundle-branch block and a fluoroscopic examination of the heart showed lessened pulsations and a widening of the left ventricle. An attack of apparently genuine anginal distress occurred early in his hospital stay. There was pain and a sense of constriction, especially over the left shoulder. It was quickly relieved by nitroglycerine. Other physical and anatomical findings were not noteworthy.

Present Status: Although he has tried to cooperate in psychotherapy and has granted that some of his attitudes are not reasonable, he cannot feel acceptant and kindly for more than a few days at a time. Then he begins to feel once more that he is being mistreated. He continues to see the psychiatrist and internist. There has been no essential change in his condition.

Condensation of Discussion by Medical and Psychiatric Staff

This man has a nearly lifelong pattern of striving to dominate others. Almost in spite of himself, he has time and again shown himself superior to co-workers and has come to the point of promotion. Whenever promotion has meant independent work without having to take authority over subordinates or to submit to direct supervision, he has done fairly well. However, he seems to move again into positions where he will be a supervisor, as though under the sway of an irresistible striving. His own resentment of authority, consciously so strong, seems to make it impossible for him to accept the hated role of domination, as if in terror of the hatred he fancies his subordinates must have toward him.

In situations where he cannot escape being in authority, the struggle seems to reflect itself in his physiology. The heart muscle, organ of domination and control ("lion-hearted," "to have the heart for it") along with the skeletal muscles it supplies, must do its work well if a superior position is to be maintained. In the fight between ambition and fear, the heart muscle "strives" to fulfill the demands of the former; but the blood supply to the heart itself is inadequate, as though deterred by an attitude of reluctance or surrender. In a previous situation, the back muscles, sensitized by injury, and the urethra, had been the site of "conflict."

The "coronary artery occlusion personality profile," according to Dunbar,* is that of a man torn by conflict between his ambitious tendency, which is largely unconscious, and his extreme discomfort as he is about to succeed in his ambitions. It is as though the function of bold, masterful action were denied at its source by a last minute recoiling of the biologic drives: the autonomic regulation of blood supply to the heart is not included in the seemingly purposeful action leading to success.

Such a conflict between opposite physiological actions is a counterpart of the psychic conflict between the striving to dominate and the need to be loved. Responses of this kind, where processes of psyche and soma run parallel, are common in the psychosomatic disorders. We may assume that the constitution and personal history of this man have led to the type of reactions described. But lack of further knowledge of the patient prevents fruitful speculation as to precisely how this was effected.

* Dunbar, Flanders: *Psychosomatic Diagnosis*. New York, Paul B. Hoeber, 1943.

BOOK NOTICES

Cybernetics. By NORBERT WEINER. Price $3.00. Pp. 194. New York, John Wiley & Sons, 1948.

The title of this book is derived from a Greek word related to the function of governing or controlling. It discusses the mathematics, mechanisms, and implications of the feedback device—that is, the use of some of the total energy of a unit for regulating or directing that unit. The analogy between the steam engine governor, the human brain, and the new computing machines is examined with broad implications regarding the future of the latter and the effects thereof upon industry and industrial organization. The most important chapters for psychiatrists are the last two—on psychopathology and on communication—but even these are highly deductive. (Karl Menninger, M.D.)

Preparation of Scientific and Technical Papers. 3rd. ed. By SAM TRELEASE AND EMMA YULE. Price, $2.00. Pp. 125. Baltimore, The Williams & Wilkins Co., 1936.

If you want something to put in the hands of your secretaries to study, thereafter to guide and correct you in your scientific writings, I can recommend this little book. (Karl Menninger, M.D.)

Big Sky. By A. B. GUTHRIE, JR. Price, $3.50. Pp. 386. New York, William Sloane Associates, 1947.

This is an adventure story, a pioneer story, a story of a very schizoid boy who ran away from home in Kentucky in the early 1830's and worked his way up the Missouri River to the Yellowstone and Jackson Hole country. He became a mountain man, a guide, a trapper, the husband of an Indian. It is a raw, vivid description of self-destructiveness in many forms. (Karl Menninger, M.D.)

The Labor Leader. An exploratory study. By ELI GINZBERG. Price, $3.00. Pp. 191. New York, The Macmillan Company, 1948.

This consists of a brief, stimulating study on theories of leadership followed by a review of American labor leaders in general, and the activities of one anonymous young labor leader in particular who was studied from the beginning of his career through the immediate accomplishment of certain results including the organization of a union and the management of a strike. The final and perhaps most suggestive chapter is entitled "Labor Leader—Bureaucrat or Statesman." (Karl Menninger, M.D.)

Child Therapy. A Casework Symposium. Edited by ELEANOR CLIFTON AND FLORENCE HOLLIS. Price $3.25. Pp. 217. New York, Family Association of America, 1948.

This is a book by social workers about their experiences in casework with children. In the introduction, it is pointed out that "Guidance or Counselling is no new function of a family agency; the newer emphasis in casework lies in the fact that counselling for certain cases has been shifting more in

the direction of psychotherapy, and that children are now taken more fully into treatment." The trend toward the practical application of psychoanalytical principles to the problems of family casework has helped to make caseworkers aware that children are active participants in family life and are able to take some responsibility for their own development. (Mrs. Marjorie H. Orth)

Projective Methods. By LAWRENCE K. FRANK. Price $2.75. Pp. 86. Springfield, Ill., Charles C. Thomas, 1948.

This monograph presents a theoretical rationale for projective methods of studying personality. Frank relates the development of such techniques to the changing orientation of professional psychologists—away from mechanistic empiricism toward dynamic processes underlying individual personality. He does not fully meet the problem of retaining both clinical richness and controlled checks on errors of subjective judgment, and seems to imply that controlled study of groups cannot contribute to the understanding of dynamic processes in the individual. Hence he gives insufficient attention to such research procedures as comparing independently defined criterion groups through blind scoring of clinically significant, molar variables applied to projective material; matching procedures, etc. Otherwise the book fulfills well its purpose of placing projective techniques in their proper context in the development of scientific psychology. (William R. Morrow, M.D.)

Father Land. By BERTRAM SCHAFFNER. Price $3.25. Pp. 203. New York, Columbia University Press, 1948.

This compact and interesting report describes the procedures used at a Military Government Screening Center in Germany. Psychiatric and anthropological concepts are brought to bear upon the problem of understanding the Germans, and particularly of discerning in them those traits which characterize Nazis and non-Nazis. In contrast to some studies of so-called national character, this one is solidly factual rather than impressionistic, being based primarily upon test and interview materials drawn from the cases examined at the screening center. The author does not believe that the Germans "should be regarded as suffering from a national form of mental disease"; instead he describes "those standard aspects of everyday behavior which Germans consider acceptable and normal and healthy," and relates them in turn to family life, education, the occupational structure and political beliefs. (Louisa P. Holt)

Psychology for Pastor and People. By JOHN SUTHERLAND BONNELL. Price, $2.50. Pp. 225. New York, Harper and Bros., 1948.

A lot of ministers do "spiritual counseling." Probably the most ingenious and effective minister who does "spiritual counseling" in his parish is Dr. Bonnell. The present book reflects the quality of his work and shows considerable progress beyond his earlier presentation in *Pastoral Psychiatry.* Few ministers are doing what Dr. Bonnell describes, but his point of view and his work are of great significance to the church and to the entire field of psychotherapy. (Robert A. Preston, Chaplain)

Dictators & Disciples from Caesar to Stalin. By GUSTAV BYCHOWSKI. Price $4.25. Pp. 262. New York International Universities Press, 1948.

In what the author describes as the new science of the psychoanalytic interpretation of history, he here presents brief biographical sketches of six dictators emphasizing the psychological factors in their own lives which led to their exaltation of autocracy, and incidentally to their downfall. The result is more suggestive than definitively informative, and the mysterious secret of magnetic leadership still eludes us. (Karl Menninger, M.D.)

Take Up Thy Bed and Walk. By DAVID HINSHAW. Price $2.75. Pp. 262. New York, G. P. Putnam's Sons, 1948.

This book is a very complete picture of the working dynamics of the Institute of Crippled and Disabled, New York City. Its opening chapter is rather sentimentally devoted to picturing the deficiencies through the ages in the care of individuals born physically incomplete or crippled through disease or accident. It has a complete glossary of terms pertinent to rehabilitation as well as an excellent bibliography. It is enlightening information for those individuals new to the rehabilitation field, but does not offer any ideas for the experienced worker. It takes the form of an excellently written handbook telling of the work of this leading Institute in the field of rehabilitation. (Edna L. Vehlow)

The Lonely Ones. By WILLIAM STEIG. Price $1.50. Pp. 103. New York, Duell, Sloan and Pearce, 1942.

A number of people reviewing these drawings would probably agree that a certain percentage are very meaningful, others humorous, and the rest senseless or obscure. However, there would probably be complete disagreement as to which drawings fall into which category. This provocative book invites speculation about the author's psyche rather than a review of the contents as such. (Ruth I. Barnard, M.D.)

Nursing For the Future. By ESTHER LUCILE BROWN, PH.D. Price $2.00. Pp. 198. New York, Russell Sage Foundation, 1948.

This is the report of a study made of present conditions in nursing and nursing education, and of probable needs for the future in the light of advances in national health services. Dr. Brown recommends that practical nurses be trained to function with professional nurses in an integrated service team. She offers definite suggestions for the improvement of conditions of education and work which will enable hospitals and other health agencies to meet the public demand for qualitative and quantitative nursing service. (Kathleen Black, R.N.)

Contributions to Psycho-Analysis, 1921–45. By MELANIE KLEIN. Price $5.25. Pp. 416. London, The Hogarth Press, 1948.

This volume consists of a collection of seventeen of Klein's papers which appeared in various journals between 1921–45, plus a contribution published in 1933 in *Psycho-Analysis Today.* To her paper "Symposium on Child Analysis" which was originally published in 1927 the author has added a postscript in which she again deals with the controversy between Anna

Freud and herself. This postscript which appears on pages 182–184 is recommended for special attention from readers. (Mary Leitch, M.D.)

An Introduction to Clinical Psychology. L. A. Pennington and Irwin A. Berg, eds. Price $5.00. Pp. 595. New York, Ronald Press, 1948.

The editors of this book have taken the position that there is a place for an introductory "survey" course in clinical psychology. They have put together a series of chapters which are largely condensations of courses in tests and measurements, individual intelligence testing, diagnostic testing, projective techniques, counselling and psychotherapy, abnormal psychology, psychology of personality, and behavior problems of children. This is presented in an effort, as the editors say, "to describe eclectically ... what clinical psychologists do." If they had limited themselves to clinical *methods* and had not tried to cover *content*, the book would have been much more useful. (Robert C. Challman, M.D.)

Psychiatry and the War, 1st ed. Frank J. Sladen, ed. Price $5.00. Pp. 505. Springfield, Ill., Charles C. Thomas, 1943.

This is an excellent compendium of papers presented at the Conference on Psychiatry, Ann Arbor, Michigan in October 1942. Reviewing the broader social implications of psychiatric knowledge, the work is an attempt to determine how our present day psychiatric knowledge might be applied to the problems of a world at war and represents an attempt to probe every area of the field of Psychiatry in an effort to crystalize psychiatric thought for a more useful and practical application during the post war period. (I. Arthur Marshall, M.D.)

Psychodrama. By J. L. Moreno. Price $6.00. Pp. 428. New York, Beacon House, 1946.

Moreno says that only a literary, word-to-act reduplication of actual psychodramatic sessions can give one an approximation of psychodramatic experience. However, with rapidly growing interest in group psychotherapy he felt that an immediate communcation of his discoveries and methods was required; hence this "compromise." Even then it is a prolix presentation of the theoretical and practical issues of psychodrama which may discourage its reading by any except specialists in this field. (Mary Douglas Lee)

Normal and Abnormal Psychology. By J. Ernest Nicole. Price $2.00. Pp. 96. London, George Allen and Unwin Ltd. 1948.

The author tries to present the principles of normal and abnormal psychology and their applications, plus a synopsis of neuro-anatomy. He gives lip-service to modern concepts of his subject. The section on basic psychology lists many theories about personality and criticizes each. The psychopathological section contains a good critique of Freud's concept of psychosexual development along with an interesting comparison of Jung's and Adler's contribution to this field. (Harry H. Wagenheim, M.D.)

Practical Psychiatry and Mental Hygiene. By Samuel W. Hartwell. Price, $3.75. Pp. 439. New York, McGraw-Hill Book Company, 1947.

Here is a book by an old friend. I think his *Fifty-Five Bad Boys* is a classic because of the psychiatric healing tone imparted in the narration, and so I turned to this book most hopefully. I was a little disappointed: first, because I learn that it is a compilation of his lectures to nurses, which is not clear from the title page, and secondly, because the presentation is for the most part along conventional lines of pre-Freudian psychiatry. (Karl Menninger, M.D.)

Doctor Freud. By EMIL LUDWIG. Price $3.00. Pp. 311. New York, Hellman, Williams & Company, 1947.

By his own admission a prolific biographer becomes so stirred up by the remarks of a garage boy and a garrulous dinner partner (both of whom use technical phrases not introduced by Freud) that he writes a denunciation of the great scientist with the use of out-of-context quotations, sneering allusions, false interpretations, and vulgar implications. This book is tendentious, pretentious, dishonest and disingenuous. (Karl Menninger, M.D.)

Contemporary Schools of Psychology. Revised ed. By ROBERT S. WOODWORTH. Price $3.00. Pp. 279. New York, The Ronald Press, 1948.

The author again attempts to give an "objective" and all-embracing account of different psychological schools. It will not surprise the psychoanalytically oriented that in 1931 Woodworth felt that Adler's conceptions were easier to grasp than those of Freud, while in 1948 "the academic psychologist finds it much easier to go along with Horney than with Freud." A "middle of the roader" prefers gentle slopes to bold mountains to use one of Woodworth's confessional metaphors. (Rudolf Ekstein, Ph.D.)

Critique of Class as Related to Social Stratification. By C. P. LOOMIS, J A. BEEGLE AND T. W. LONGMORE. Price $1.50. Pp. 21. New York, Beacon House, 1948.

A fairly comprehensive review of the literature dealing with social stratification is presented in this monograph, and some of the difficulties in working with the concept of social class are discussed. Citing the results of a number of studies of small communities, the authors suggest "friendly visiting" as a criterion of social class: people who visit freely at each others' homes are likely to have the same class standing in the community; those who do not are likely to be of differing class status. It seems to be a useful enough suggestion, although some faults can of course be found with it. (Louisa P. Holt)

The Inner World of Man. By FRANCES G. WICKES. Price $5.00. Pp. 33 with 79 plates. New York, Henry Holt and Company, 1948.

The Inner World of Man is painted very beautifully by the author, but therein lies its greatest weakness. One gets the impression from this book that emotional difficulties all arise from a confusion over what ones "life task" is and how it can be fulfilled. This, however, is an almost unavoidable result of any attempt to really make clear the "system" of Jung. Some interesting case material is presented by the author as well as some fascinating artistic productions of patients in treatment. (It is unfortunate that it is all

viewed through the rose colored glasses of the analytic psychologist and has to be sugar coated in order not to offend some spurious moral code which has no place in scientific investigation of mental illness.) Nevertheless, the book is the most intelligible of any the reviewer has seen that deals with the psychological constructs of Dr. C. G. Jung. (Edward C. Adams, M.D.)

Handbook of Tests in Parapsychology. By BETTY M. HUMPHREY. Pp. 152. Durham, N. C., Duke University, 1948.

This most recent handbook will serve as a very usable guide to the growing number of research neophytes in this frontier of knowledge. It is not intended as evidence for or against the initial question, Do such phenomena exist? Parapsychology has gone on to the later questions of: Under what conditions are these psychic abilities manifest, and how are they related to better-understood personality functions?

The manual includes descriptions of, and pitfalls of methods used for testing extrasensory perception (the acquisition of knowledge without the use of the known senses), and psychokinesis (exertion of force on external objects by the direct influence of the mind). It ends with a discussion of controls on the experimenter, problems in experimental design, and pioneer problems in research. (Lester Luborsky, M.D.)

The Abnormal Personality. By ROBERT W. WHITE. Price $5.00. Pp. 613. New York, The Ronald Press, 1948.

The college students using this as a textbook can be quite appreciative of the choice and organization of material. Inclusion of a section to alleviate "medical student's disease," as well as many practical mental hygiene hints increase its usefulness. Presentation of five cases in the opening section with subsequent referral to them makes for a more complete and dynamic understanding of psychological processes. More "depth psychology" could have been included and the dual instinct theory could have been mentioned in what was otherwise a fairly comprehensive presentation. The explanation of various psychotherapeutic methods is good and shows the reader the oft neglected aspect of just what might be done for the abnormal personality. (Jack A. Dunagin, M.D.)

Modern Trends in Psychological Medicine. NOEL G. HARRIS, ed. Price $10.00. Pp. 450. London, Paul B. Hoeber, Inc., 1948.

This is not a textbook but rather a brief survey of current trends in psychiatric thought and practice. Harris is assisted by seventeen collaborators, resulting in a cross-sectional presentation of a number of different points of view concerning emotional disturbance, ranging from the Kraepelian concept of mental diseases to the sociological concept of states of disequilibrium between individuals and their milieu. The approach is characteristically eclectic, practical, and often wise. It is disturbing, however, that only one brief chapter is devoted to individual psychotherapy, and that important modern trends in this field are entirely neglected. (Donald J. Watterson)